Date: March 22, 1995 BQC-95-010

To: Nursing Homes NH 05

From: Judy Fryback, Director
Bureau of Quality Compliance

Bed-Hold in Nursing Facilities

This memorandum services to correct the Bureau of Quality Compliance (BQC) numbered memo BQC 94-075 "Bed hold in Nursing Facilities" in regard to the BQC code interpretation number 2 below. The corrections to code interpretation number 2 will be in bold and underlined. BQC has received additional clarification from the Health Care Financing Administration (HCFA) via program letter No. 94-28 concerning "Bed-hold Policies for Long Term Care (LTC) Facilities--INFORMATION," a copy of which is attached to this memo.

For further clarification, the Wisconsin Medicaid State Plan allows bed-hold coverage for therapeutic leaves of any length and for hospital stays up to 15 days. Therapeutic bed-hold will not be addressed in this memo; you are advised to refer to your Wisconsin Medical Assistance Provider Handbook in regard to therapeutic leave bed-hold.

In addition, the BQC will provide a revised code interpretation in this memorandum regarding the bed to which a resident is to be admitted upon return to the facility following a bed-hold absence.

Program letter No. 94-28 states HCFA's interpretations regarding the laws and regulations regarding bed-hold for both the Medicaid and Medicare programs.

A. HCFA's current bed-hold policy for **Medicaid** is as follows:

1. Preadmission bed-hold changes are prohibited for prospective residents. A facility may not charge a prospective resident to hold a bed prior to admission.

2. Once a Medicaid eligible person has been admitted to the facility, bed-hold charges for days beyond the bed-hold hospitalization period covered under Medicaid (15 days in Wisconsin) are non-covered services which may be voluntarily paid by the resident or others on the resident's behalf. A Medicaid resident whose bed-hold days expire during a hospitalization leave may elect to pay to hold the bed beyond the 15 Medicaid bed-hold days.

3. Once all bed-hold options (Medicaid payment and private election to pay) have expired, the Medicaid recipient may return upon the first availability of a semi-private bed in the facility.

4. Prior to and at the time of transfer, resident must have in writing the following bed-hold information:

   a. the length of time Medicaid will make payment to hold the bed;

   b. the option to make payment privately for days beyond the Medicaid bed-hold limit; and

   c. the amount of the facility's daily charge for bedhold.

B. HCFA's current bed-hold policy for **Medicare** is as follows:

1. Preadmission bed-hold charges are prohibited for prospective residents. A facility may not charge a prospective resident to hold a bed prior to admission.

2. The Medicare program does not make bed-hold payments even after a person's initial admission to a facility.

3. There is no guarantee of return of a Medicare eligible individual to the first available semi-private bed in the facility.

4. Medicare eligible individuals may choose to make bed-hold payments to the facility as long as the payment is solely for the purpose of reserving the bed during the recipient's absence.

5. Prior to and at the time of transfer residents must have advanced notice of the following bed-hold information:

   a. Medicare non-bed-hold policy;

   b. the option to make payment privately for temporary leave days; and

   c. the amount of the facility's daily charge for bed-hold.

In addition, residents who are paying privately (are neither Medicaid nor Medicare recipients) must also be given notice prior to and at the time of transfer of the facility's bed-hold policy and charges for bed-hold.

The following is a BQC code interpretation to address the issue of which bed a resident returns to after hospitalization or therapeutic leave:

1. If the individual is a **Medicare** (Title 18) Part A beneficiary who goes to the hospital while in receipt of Medicare Part A coverage in the NH and elects to pay privately for bed-hold while in the hospital:

   -the person returns to "the" bed in which he/she resided prior to transfer to the hospital

2. If the individual is a **Medicare** (Title 18) Part A beneficiary who goes to the hospital while in receipt of Medicare Part A coverage in the NH and elects to <u>not</u> pay privately for bed-hold while in the hospital:

   -the person returns to "a" bed in the Medicare certified part of the facility if eligible for Medicare Part A coverage upon return to the facility, **if a bed is available** or

   -the person returns to "a" bed in the facility if not eligible for Medicare Part A coverage upon return, **if a bed is available.**

3. If the individual has been residing and **paying privately** in a Medicare (Title 18) bed in the NH and chooses to pay privately to hold the bed in his/her absence:

   -the person returns to "the" bed in which he/she resided prior to the absence.

4. If the individual is a **Medicaid** (Title 19) resident who returns to the nursing home within the 15-day Medicaid bed-hold limit:

   -the person returns to "the" bed in which he/she resided prior to the absence.

5. If the individual is a **Medicaid** (Title 19) resident who has exhausted the Medicaid 15-day bed-hold limit and elects (resident or responsible person) to pay privately beyond the Medicaid 15 day bed-hold to hold the bed:

-the person returns to "the" bed which he/she resided prior to the absence.

6. If the individual is a **Medicaid** (Title 19) resident who has exhausted the Medicaid 15-day bed-hold and does not elect to pay privately for a bed-hold extension beyond the 15-day Medicaid bed-hold:

-the person returns to "the first available bed in a semi-private room."

7. If the individual is a privately-paying resident or a Medicaid recipient upon transfer to the hospital and returns to the nursing home eligible for a level of care under Medicaid:

-each has the option of choosing the Medicare bed or returning to "the" private pay or Medicaid bed he/she resided in prior to the transfer to the hospital, providing the bed was held in the manner of 1., 3., 4. and 5., above.

If you have any questions regarding bed-hold in nursing facilities, please contact your Regional Field Operations Director.

Attachment

cc: -BQC Staff
-Office of Legal Counsel
-Ann Haney, DOH Admin.
-Kevin Piper, BHCF Dir.
-HCFA, Region V, M. Dykstra
-Illinois State Agency
-Ohio State Agency
-Michigan State Agency
-Indiana State Agency
-Minnesota State Agency
-WI Coalition for Advocacy
-Serv. Employees Inter. Union
-WI Counties Assn.
-WI Health Info. Mgmt. Assn.
-WI Assn. of Homes & Serv/Aging
-St. Med. Society (Comm. Aging…)
-WI Health Care Association
-WI Assn. of Medical Directors
-Admin., Division of Care and Treatment Facilities
-WI Assn. of Hospital SW and Discharge Planners
-Bd. on Aging & Long Term care
-Bur. of Design Prof., DRL
-LTC BQC Memo Subscribers
-Mark Bunge, BPH
-DD Board

Department of Health & Human Services
Health Care Financing Administration
Region V
105 West Adams Street, 15th Floor
Chicago, Illinois 60603-6201

Refer to: CO20

November 1994

Division of Health Standards & Quality Regional Program Letter No. 94-28

Subject: Bed-Hold Policies for Long Term Care Facilities - INFORMATION

These instructions were received from our Central Office and summarize the policies regarding bed-hold payments made during a resident's absence from a Medicaid nursing facility (NF) or Medicare skilled nursing facility (NF).

A. Medicaid. –

1. Law and Regulations.--Under Medicaid payment regulations in 42 CFR 447.40, Federal financial participation is available if a State plan includes provision for bed-hold payments during a recipient's temporary absence from an inpatient facility. (To qualify under this provision, an absence for any purpose other than required hospitalization must be provided for in the patient's plan of care.)

To satisfy Medicaid NF requirements for participation in Sections 1919(c)(2)(D)(i)-(ii) of the Act and in 42 CFR 483.12(b)(1)-(2), a NF must tell residents departing for hospitalization or therapeutic leave about the State's bed-hold payment policy. This information must be in writing and must specify the number of days the State Medicaid program covers, if any, and the NF's policies regarding bed-hold periods. If a Medicaid eligible resident's absence from the NF exceeds the bed-hold period provided for in the State plan, Section 1919(c)(2)(D)(iii) of the Act and 42 CFR 483.12(b)(3) guarantee the resident readmission to the facility immediately upon the first availability of a bed in a semiprivate room in the facility, if, at the time of readmission, the resident requires the services provided by the facility.

The Medicaid NF requirements for participation in Section 1919(c)(5)(A)(iii) of the Act and 42 CFR 483.12(d)(3) prohibit a NH from accepting any gift, money, donation, or other consideration as a precondition for a Medicaid eligible individual's admission, expedited admission, or continued stay in the facility.

The Medicaid NF requirements for participation in Sections 1919(c)(1)(B)(iii)-(iv) of the Act and in 42 CFR 483.10(b)(5)-(6) require a NF to inform each resident, upon admission, and periodically thereafter, of services for which the resident can be charged, as well as the amount of the charge.

2. Interpretation.--The Medicaid program does not make payments to reserve a bed before a prospective resident's initial admission to a facility, since 42 CFR 447.40 provides authority for Medicaid bed-hold payments only after an individual has been admitted to the facility. Further, under Section 1919(c)(5)(A)(iii) of the Act and 42 CFR 483.12(d)(3), a NF may not accept preadmission bed-hold payments from a Medicaid eligible prospective resident or from any other source on that individual's behalf.

When a Medicaid eligible individual who has been admitted to the facility takes a temporary leave of absence from the facility, Medicaid can make bed-hold payments under 42 CFR 447.40. Bed-holds for days of absence in excess of the State's bed-hold limit are considered non-covered services for which the resident may elect to pay. Under Section 1919(c)(1)(B)(iii) of the Act and 42 CFR 483.10(b)(5)-(6), the facility must inform residents in advance of the period whether Medicaid payment will be made for the holding of a bed, their option to make bed-hold payments if hospitalized or on a therapeutic leave beyond the State's bed-hold period, and of the amount of the facility's charge. Thus, a Medicaid eligible resident whose absence from the facility exceeds the State's bed-hold limit can elect either to:

- Ensure the timely availability of a specific bed upon return by making bed-hold payments for any days of absence in excess of the State's payment limit, or
- Return upon the first availability of a semiprivate bed in the NF in accordance with Section 1919(c)(2)(D) of the Act and 42 CFR 483.12(b)(3). The first available bed refers to the first unoccupied bed that is not being held because a resident (regardless of source of payment) has elected to make a payment to hold that bed.

A NF may not impose a minimum bed-hold charge (e.g., a 3-day minimum charge on all bed reservations) because such minimum charges may result in duplication of Medicaid payment for covered services.

B. Medicare. –

1. Law and Regulations.—The Medicare SNF requirements for participation (Section 1819 of the Act) contain no provisions corresponding to those of the Medicaid statute in Sections 1919(c)(2)(D) and (c)(5)(A)(iii) of the Act. Unlike the Medicaid regulations in 42 CFR 447.40, the Medicare regulations do not include any provisions authorizing the program to make bed-hold payments.

The Medicare SNF requirements for participation in Section 1819(c)(1)(B)(iii) of the Act and in 42 CFR 483.10(b)(5)-(6) require a SNF to inform each resident, upon admission and periodically thereafter, of services for which the resident can be charged as well as the amount of the charge.

Under the Medicare provider agreement regulations in Section 1819(c)(1)(B)(iii) of the Act and in 42 CFR 489.32(a)(2), a SNF may charge a resident for services in excess of (or more expensive than) covered services only when the services are furnished at the resident's request.

The Medicare provider agreement regulations in 42 CFR 489.22(d)(1) prohibit Medicare providers (including SNFs) from charging for an agreement to admit or readmit an individual on some specified future date for covered inpatient services.

2. Interpretation.—Like Medicaid, Medicare does not make bed-hold payments prior to a prospective resident's initial admission to a facility. Further, under the terms of its Medicare provider agreement, a SNF may not accept preadmission bed-hold payments from, or on behalf of, a person in return for admitting that person on some specified future date for covered inpatient services.

Unlike Medicaid, Medicare has no legal authority to make bed-hold payments even after a person's admission to a facility, and the Medicare SNF requirements for participation do not guarantee a return to the first available semiprivate bed in the facility.

When temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF, as long as the SNF's acceptance of such payments does not represent a prohibited provider practice under 42 CFR 489.22(d)(1). This means that the payment to the SNF is solely for the purpose of reserving the bed during the recipient's absence and does not represent a payment for the act of readmission on some specified future date for covered inpatient services. Under Section 1819(c)(1)(B)(iii) of the Act and 42 CFR 483.10(b)(5)-(6), the facility must inform residents in advance of their option to make such payments, as well as the amount of the facility's charge.

Please ensure appropriate staff are apprised of these policies. If you have any questions, contact your Principal Program Representative.

/s/ Sally Jo Wieling, Acting Branch Chief
Survey & Certification Operations Branch, Division of Health Standards & Quality

cc: Medicaid State Agencies